

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155248		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 09/09/2011	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BRENTWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 30 EAST CHANDLER AVE EVANSVILLE, IN47713			
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F0000	<p>This visit was for a post survey revisit [PSR] to the Recertification and State Licensure survey, completed on 7/22/11. This survey visit included a PSR to the investigation of Complaint #IN00093538 and Complaint #IN00093878, completed on 7/22/11.</p> <p>This visit was in conjunction with a PSR to the investigation of complaint number IN00094731, completed on 8/19/11.</p> <p>This visit was in conjunction with the investigation of complaint number IN00096074.</p> <p>Complaint Numbers: IN00093538 Not Corrected. Federal/State deficiencies related to the allegations are cited at F157 and F309.</p> <p>IN00093878 Not Corrected. Federal/State deficiencies related to the allegations are cited at F282.</p> <p>Survey Dates: September 7-9, 2011</p> <p>Facility number: 000152 Provider number: 155248 AIM number: 100267510</p> <p>Survey team:</p>			F0000	<p>Preparation, submission and implementation of this plan of correction does not constitute an admission of or an agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal guidelines.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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	Amy Wininger RN, TC Diane Hancock RN Census Bed type: SNF/NF: 77 Total: 77 Census payor type: Medicare: 6 Medicaid: 47 Other: 24 Total: 77 Sample: 10 Supplemental Sample: 7 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed 9/15/11 Cathy Emswiller RN						

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F0157 SS=D	<p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified of a change in condition, for 1 of 1 resident with a fractured ankle, in the sample of 10, in that the resident could not bear weight and required a mechanical lift for transfer and the facility failed to notify the physician of the change in</p>			F0157	<p>1. Corrective actions for resident #44 were taken as follows: physician aware of current status and updated with change in condition as warranted.</p> <p>2. All other residents with the potential to be affected by the alleged deficient practice have been identified and corrective actions</p>		09/27/2011

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	<p>condition in a timely manner. (Resident #44)</p> <p>Finding includes:</p> <p>Resident #44's clinical record was reviewed on 9/8/11 at 10:07 a.m. The resident's diagnoses included, but were not limited to, hypertension, senile dementia, anxiety, and depression.</p> <p>Nurses' notes, dated 8/21/11 at 8:19 a.m., indicated the following: "...Res. unable to reposition self while in bed. Incontinent of B/B [bowel/bladder]. Res. unable to sit on side of bed with one assist. Res. is extensive assist of 2 to sit up and cannot keep balance while sitting. When staff lets go of res, res. immediately falls back. Res. wrapped gown around neck and arms became stuck. Res. pajamas changed immediately. Did not answer one question appropriately entire shift. Unable to bear any weight. Noted res. left foot/ankle with +3 nonpitting edema. No bruise or redness noted. Impaired AROM/PROM [active and passive range of motion]. Res. unable to put shoes on and gripper socks worn instead. Unable to follow any direction. Lift used for transfers d/t [due to] unable to bear weight. Res. verbal with staff and other residents. res. 1:1 with staff @ nurse's station d/t upsetting other residents. Res.</p>				<p>taken as indicated.</p> <p>3. The following measures were implemented to prevent any incidents of the alleged deficient practice: Licensed staff were re-educated related to physician and family notification of change. Status charting will be reviewed daily per DNS/ designee daily and audited for notification of change.</p> <p>4. Corrective actions will be monitored by ED in monthly QA&A meeting monthly for 6 months and no further corrective actions are necessary.</p> <p>5. Correction will be completed by Sept. 27, 2011.</p>		

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	<p>screamed when staff attempted to transfer. Res. combative with staff. Hit CNA in head and pinched this nurse several times while attempting to provide care. Res. leaning to the left while sitting in w/c [wheelchair]. Res. constantly scooting buttocks to edge of chair while sitting and sounding tabs alarm..."</p> <p>8/21/11 8:33 a.m., "PP X 2 [pedal pulses times two] BLE [bilateral lower extremities]...No edema RLE [right lower extremity]. Skin color and warmth = BIL [bilateral] feet. No bruises or edema noted L [left] hip. Buttocks free from O/As [open areas]...Res. encouraged to elevate BLE, but did not understand..."</p> <p>8/21/11 6:30 p.m., "Sitting upright in chair earlier in day and as this nurse assumed care at 1500 [3:00 p.m.]. Confused, calling out, in constant motion, requires frequent redirection. As evening has progressed, resident has slumped on right side some, but straightens self up and is not consistent..."</p> <p>8/21/11 10:50 p.m., "Res. transferred to bed per lift and assist of 2. Res. tolerated lift well and was cooperative in crossing arms during transfer. Pillow placed between knees for comfort d/t prior c/o [complaint of] pain. Res. con't [continues] to be unable to bear weight. Slumped to R [right] side while in w/c. Pillow used to prop resident. Gripper</p>						

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	<p>socks can't to be worn...PRN [as needed] Lortab [narcotic pain medication] given at 1900 [7:00 p.m.] for c/o BLE [bilateral lower extremities] pain and helpful..." 8/22/11 3:05 a.m., "Noted LLE [left lower extremity] +3 nonpitting edema up to knee this night. While in bed, leaning to the right...Assessment: VS [vital signs]: 98.4 [temperature], 104/58 [blood pressure], 20 [respirations], 78 [heart rate], 97% RA [oxygen saturation on room air]. RLL [right lower lobe] with congestion...Face flushed. Heartbeat irregular. LLE +3 nonpitting edema up to knee. Entire L outer ankle blue and purple. L knee/ankle inwardly rotated...Groin free from bruises. Abnormal eye movements - more dominant in R eye then L...Res. unable to lift LLE... Response: Pillow placed between knees. MD [medical doctor] and [name of family member] notified. Sent to [name of hospital]..."</p> <p>The record indicated the resident was admitted to the hospital with a CT [computerized tomography] scan of the ankle indicated, "1. Nondisplaced fracture of the lateral malleolus with surrounding hematoma or edema. 2. Demineralization and degenerative changes."</p> <p>A general note from the Alzheimer Care</p>						

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	<p>Director, dated 8/21/11 at 10:34 a.m., indicated the following: "Nursing staff reported to this writer this morning that lift was required to get resident out of bed. Staff stated this resident requires at least two assist and even with two it is extremely difficult.</p> <p>The Director of Nurses [DoN] was interviewed on 9/8/11 at 3:50 p.m. She indicated the resident had been on the skilled unit for awhile and had been transferred back to the Alzheimer's Care Unit [ACU]. She indicated, during her investigation of the injury of unknown origin, the nurse had indicated she called the doctor on 10/22/11 because the swelling had spread and there was a bruise and some abnormal vital signs. She did not indicate why she didn't call the physician when the resident couldn't bear weight and required a lift to be transferred and was screaming when they attempted to transfer her.</p> <p>This federal tag was cited on 7/22/11 and related to complaint number IN00093538. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>						

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F0282 SS=D	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review the facility failed to ensure a care plan intervention was followed for a resident at risk for falls, for 1 of 4 sampled residents at risk for falls in the total sample of 10. Resident #12 was care planned to have a pressure alarm when seated in a stationary chair, did not have the alarm in place, and experienced a fall.</p> <p>Finding includes:</p> <p>The clinical record of Resident #12 was reviewed on 09/07/11 at 2:20 P.M.</p> <p>The diagnoses of Resident #12 included, but were not limited to, Dementia.</p> <p>Resident #12 was observed, on 09/07/11 at 10:50 A.M., sitting in stationary chair without an alarm.</p> <p>A Nursing Note, dated 09/06/11 at 1800</p>			F0282	<p>1. Corrective actions for resident #12 were taken as follows: fall prevention interventions in place as per plan of care.</p> <p>2. All other residents with the potential to be affected by the alleged deficient practice have been identified and corrective actions taken as indicated.</p> <p>3. The following measures were implemented to prevent any incidents of the alleged deficient practice: Nursing staff were re-educated related to following resident plan of care, including but not limited to, fall prevention interventions. Random audits of fall prevention interventions being in place as indicated per resident specific plan of care will be conducted per DNS/designee, 3x week for 4 weeks, then 2x week for 4 weeks and then weekly for 4 weeks.</p> <p>4. Corrective actions will be monitored by ED in monthly QA&A</p>		09/27/2011

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	<p>[6:00 P.M.], indicated, "Resident fell while bending over attempting to pick an item up off the floor. This nurse was feeding another resident and saw resident bending over and went to assist him, but resident fell on bottom before nurse could get to him...chair alarm placed on stationary furniture to alert staff when resident attempts to transfer on own."</p> <p>The CNA Assignment Sheet, provided by the ADON [Assistant Director of Nursing] on 09/07/11 at 10:45 A.M., updated 08/31/11, indicated Resident #12 was to have a pressure alarm to stationary furniture.</p> <p>A Care Plan for falls, initiated on 08/24/11 included, but was not limited to, an intervention of, "Pressure alarm to stationary furniture."</p> <p>In an interview with Unit Manager #2, on 09/07/11 at 3:00 P.M., she indicated, "[Resident #12] did not have an alarm on his chair when he fell on 09/06/11, we added that as an intervention on 09/06/11."</p> <p>The Policy and Procedure for "Falls Management Clinical Guidelines," provided by the DoN [Director of Nursing] on 09/09/11 at 2:15 P.M., indicated, "The center implements the</p>				<p>meeting monthly for 6 months and no further corrective actions are necessary.</p> <p>5. Correction will be completed by Sept. 27, 2011.</p>		

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F0309 SS=D	<p>falls prevention and intervention program including:...Appropriate interventions are implemented..."</p> <p>This federal tag was cited on 7/22/11 and related to complaint number IN00093878. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-35(g)(2)</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure 1 of 1 supplemental sample resident reviewed for pain and pressure sore, in the supplemental sample of 5, received appropriate pain management, in that the resident had pain with inadequate control and lacked assessment of relief from pain medication. (Resident #67)</p> <p>Finding includes:</p>		F0309	<p>1. Corrective actions for resident #67 were taken as follows: pain assessment updated, medications reviewed and adjusted per physician order, care plans reviewed and updated as needed.</p> <p>2. All other residents with the potential to be affected by the alleged deficient practice have been identified and corrective actions taken as indicated.</p> <p>3. The following measures were implemented to prevent any incidents</p>		09/27/2011	

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	<p>Resident #67 was observed on 9/7/11 at 10:15 a.m. She was in a wheelchair in the hallway. She was holding up her left hand. It was observed to be contracted, with a white wash cloth and foam pad between the fingers and the palm. She was tearful and making a crying noise. When queried, she held up her left hand and nodded when asked if she was hurting and where she was hurting.</p> <p>On 9/8/11 at 10:55 a.m., the Unit Manager was observed to perform a treatment to Resident #67's palm. The resident made a crying sound and resisted when the Unit Manager attempted to separate her fingers from her palm. A white wash cloth had been placed in her hand; the Manager was able to get the wash cloth out after a short while.</p> <p>The resident's middle finger was contracted and the tip of the finger pressed against the resident's palm. When separated from the palm, there was a darker area, with some loose skin. The area did not appear to be open at that time. When the resident's fingers were released, they immediately closed in and the middle finger rested solidly against the palm. The resident was resistive and cried any time her hand was manipulated. Following the treatment, the Unit Manager indicated she was not going to</p>				<p>of the alleged deficient practice: Licensed staff were re-educated related to pain management, including but not limited to documentation, non-pharmacological interventions and evaluation of effectiveness. Random audits of pain management tools will be conducted per DNS/designee 3x weekly for 4 weeks, then 2x weekly for 4 weeks and then weekly for 4 weeks.</p> <p>4. Corrective actions will be monitored by ED in monthly QA&A meeting monthly for 6 months and no further corrective actions are necessary.</p> <p>5. Correction will be completed by Sept. 27, 2011.</p>		

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	<p>place the wash cloth back in her hand because it was too painful. When queried, she indicated she had given the resident pain medication prior to the treatment.</p> <p>At 11:15 a.m. on 9/8/11, the Unit Manager was interviewed. She indicated she had given the resident Ibuprofen [anti-inflammatory medication] for pain. She indicated she had given the medication at 10:15 a.m. The Medication Administration Record was reviewed, at that time, and the medication had not been documented. There was no indication the Unit Manager had assessed the severity of the resident's pain prior to the medication being administered or the effectiveness of the pain medication.</p> <p>Resident #67's clinical record was reviewed on 9/8/11 at 11:30 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, failure to thrive, history of convulsions, and diabetes mellitus. Nurses' notes included, but were not limited to, the following: 9/3/11 14:26 [2:26 p.m.] "Situation: Resident noted to have area in palm of left hand d/t contracted fingers and nail has protruded skin causing area measuring 1 X 0.8 X <0.1... Assessment: Area cleansed and measured and hospice called for treatment order... Response: Resident given PRN [as</p>						

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	<p>needed] Ibuprofen [anti-inflammatory medication] for general discomfort and area cleansed with NS [normal saline] and bacitracin applied with foam dressing per treatment order received from hospice. Nail care given as well. MD [Medical Doctor] notified as well as POA [name]."</p> <p>9/5/11 15:56 [3:56 p.m.] "Unable to locate area in palm of L hand. Pt. had rag rolled into hand and would not allow this RN to open fingers d/t pain. Did manage to remove rag but unable to replace or find area to apply dressing."</p> <p>9/6/11 03:21 [3:21 a.m.] "open area right palm, cleansed with NS [normal saline] and bacitracin and medipore dressing applied. foam replaced on top of dressing to reduce pressure to palm."</p> <p>A Wound Evaluation Flow Sheet indicated the following assessment on 9/3/11, length 1 [centimeters], width 0.8, depth [less than] 0.1. Exudate was identified as "purulent." Comments indicated, "clean [with] NS [normal saline], bacitracin/foam drsg [dressing] initiated today 9/3."</p> <p>The resident had the following PRN [as needed] medication orders for pain, as indicated on the physician's orders signed on 8/2/11:</p> <p>Ibuprofen [anti-inflammatory medication] give 400 mg [milligrams] by mouth every</p>						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155248		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 09/09/2011	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BRENTWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 30 EAST CHANDLER AVE EVANSVILLE, IN47713			
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	<p>6 hours as needed for pain or elevated temperature.</p> <p>Roxanol (Morphine Sulfate) [narcotic pain medication] 20 mg/ml [milligrams per milliliter] 1 ml every hour as needed for pain.</p> <p>The Medication Administration Record [MAR] for September, 2011 was reviewed on 9/8/11 at 11:15 a.m. The record indicated Roxanol had not been given during the month of September, 2011. The MAR indicated Ibuprofen had been given at the following times and dates:</p> <p>9/3/11, 11:00 a.m. 9/4/11, 9:30 a.m. 9/6/11, 9:30 a.m.</p> <p>The record lacked any indication the resident's level of pain was assessed prior to the administration of the Ibuprofen and the level of relief assessed following the medication. The resident received no PRN pain medication on 9/5/11 at 3:56 p.m., when the nurse documented the resident's wound could not be assessed, and the wash cloth replaced due to pain.</p> <p>The policy and procedure for pain management, dated as revised January 2011, was provided by the Assistant Director of Nurses on 9/9/11 at 2:35 p.m. The Guidelines included, but were not</p>						

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	<p>limited to, the following:</p> <p>"Functions of appropriate pain management include, but are not limited to:</p> <ul style="list-style-type: none"> -Recognizing and reporting pain as a 5th vital sign -Assessing pain and evaluating response to pain management interventions using a pain management scale based on resident self-report or objective assessment for the cognitively impaired -Intervention to treat pain before the pain become severe. -Using non-drug interventions to assist in pain management. -Documenting pain assessment, intervention, and evaluation activities in a clean and concise manner per the plan of care." <p>"Assessment</p> <p>Pain assessment tools: Numeric rating Scale, Verbal Descriptor Scale and PAINAD (Pain in Advanced Dementia) are utilized to screen and assess pain level for cognitively intact and cognitively impaired residents."</p> <p>This federal tag was cited on 7/22/11 and related to complaint number IN00093538. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>						

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F0314 SS=D	<p>3.1-37(a)</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident without a pressure ulcer did not develop a pressure ulcer, for 1 of 1 supplemental sample resident with a pressure ulcer, in the supplemental sample of 4, in that the resident's contracted fingers and fingernail caused a pressure ulcer on the palm, without preventive measures in place. (Resident #67)</p> <p>Finding includes:</p> <p>Resident #67 was observed on 9/7/11 at 10:15 a.m. She was in a wheelchair in the hallway. She was holding up her left hand. It was observed to be contracted, with a white wash cloth and foam pad between the fingers and the palm. She was tearful and making a crying noise.</p>		F0314	<p>1. Corrective actions for resident #67 were taken as follows: skin assessment updated, treatment orders and preventative measures reviewed. Care plans updated as needed.</p> <p>2. All other residents with the potential to be affected by the alleged deficient practice have been identified and corrective actions taken as indicated.</p> <p>3. The following measures were implemented to prevent any incidents of the alleged deficient practice: Licensed staff were re-educated related to prevention of skin breakdown and effectiveness of interventions. Random audits of skin prevention measures and appropriate interventions in place for residents at risk for skin breakdown will be completed per DNS/designee 3x</p>		09/27/2011	

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	<p>When queried, she appeared to indicate her hand was hurting.</p> <p>On 9/8/11 at 10:55 a.m., the Unit Manager was observed to perform a treatment to Resident #67's palm. The resident made a crying sound and resisted when the Unit Manager attempted to separate her fingers from her palm. A white wash cloth had been placed in her hand; the Manager was able to get the wash cloth out after a short while.</p> <p>The resident's middle finger was contracted and the tip of the finger pressed against the resident's palm. When separated from the palm, there was a darker area, with some loose skin. The area did not appear to be open at that time. When the resident's fingers were released, they immediately closed in and the middle finger rested solidly against the palm. The resident was resistive and cried any time her hand was manipulated.</p> <p>Resident #67's clinical record was reviewed on 9/8/11 at 11:30 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, failure to thrive, history of convulsions, and diabetes mellitus. Nurses' notes included, but were not limited to, the following: 9/3/11 14:26 [2:26 p.m.] "Situation: Resident noted to have area in palm of left</p>				<p>weekly for 4 weeks, then 2x weekly for 4 weeks and then weekly for 4 weeks.</p> <p>4. Corrective actions will be monitored by ED in monthly QA&A meeting monthly for 6 months and no further corrective actions are necessary.</p> <p>5. Correction will be completed by Sept. 27, 2011.</p>		

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	<p>hand d/t contracted fingers and nail has protruded skin causing area measuring 1 X 0.8 X <0.1...</p> <p>Assessment: Area cleansed and measured and hospice called for treatment order...</p> <p>Response: Resident given PRN [as needed] Ibuprofen [anti-inflammatory medication] for general discomfort and area cleansed with NS [normal saline] and bacitracin applied with foam dressing per treatment order received from hospice. Nail care given as well. MD [Medical Doctor] notified as well as POA [name]."</p> <p>A Wound Evaluation Flow Sheet indicated the following assessment on 9/3/11, length 1 [centimeters], width 0.8, depth [less than] 0.1. Exudate was identified as "purulent." Comments indicated, "clean [with] NS [normal saline], bacitracin/foam drsg [dressing] initiated today 9/3."</p> <p>The resident's most recent quarterly Minimum Data Set Assessment [MDS], dated 5/24/11, indicated the resident required extensive assistance of two persons for transfers, total care of two persons for dressing, extensive assistance of two persons for toileting, and personal hygiene. The MDS indicated the resident had functional limitations in range of motion on both sides in the upper and lower extremities. The Care Plan for</p>						

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	<p>alteration in ADL [Activities of Daily Living] function, dated 8/26/10, indicated the resident occasionally refused showers and they were to offer bed baths when that happened. Interventions also included, but were not limited to, the following: "inspect skin with care. Report reddened areas, rashes, bruising, or open areas to charge nurse," "monitor and report changes in ROM [range of motion] ability," and "nail care PRN [as needed]."</p> <p>The August, 2011 treatment record indicated the following direction, "Soft left hand protectors with finger separators (sic) on at all times as res [resident] tolerates. Remove for skin care daily." Staff initials for day, evening and night shift throughout the month had been circled.</p> <p>During interview on 9/9/11 at 8:45 a.m., the Director of Nurses [DoN] indicated Resident #67 had been assessed by the hospice nurse on 8/31/11 and had no wounds. She indicated the circles on the treatment record indicated the finger separators had not been used during the month of August and indicated it was because the resident was refusing to wear the device. She indicated, after they noted the wound from the fingernail, they got the order for a treatment and a foam dressing to pad the area, and started using</p>						

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F0323 SS=D	<p>a washcloth to separate the fingers from the palm. They had then consulted the hospice agency about getting a "therapy carrot" or a foam roller to place in the hand. She was unable to identify what interventions were attempted prior to the wound being found on the palm.</p> <p>3.1-40(a)(1)</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident had care plan interventions in place to prevent a fall, for 1 of 4 sampled residents reviewed for falls, in the total sample of 10, in that Resident #12 was care planned to have a pressure alarm, did not have a pressure alarm in place, and experienced a fall.</p> <p>Finding includes:</p> <p>The clinical record of Resident #12 was reviewed on 09/07/11 at 2:20 P.M.</p>			F0323	<p>1. Corrective actions for resident #12 were taken as follows: fall prevention interventions in place per plan of care and indicated on certified nursing assistant assignment sheet.</p> <p>2. All other residents with the potential to be affected by the alleged deficient practice have been identified and corrective actions taken as indicated.</p> <p>3. The following measures were implemented to prevent any incidents of the alleged deficient practice: Nursing staff were re-educated related to ensuring that fall</p>		09/27/2011

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	<p>The diagnoses of Resident #12 included, but were not, limited to, Dementia.</p> <p>Resident #12 was observed, on 09/07/11 at 10:50 A.M., sitting in stationary chair without an alarm.</p> <p>A Nursing Note, dated 09/06/11 at 1800 [6:00 P.M.], indicated, "Resident fell while bending over attempting to pick an item up off the floor. This nurse was feeding another resident and saw resident bending over and went to assist him, but resident fell on bottom before nurse could get to him...chair alarm placed on stationary furniture to alert staff when resident attempts to transfer on own."</p> <p>The CNA Assignment Sheet, provided by the ADON [Assistant Director of Nursing] on 09/07/11 at 10:45 A.M., updated 08/31/11, indicated Resident #12 was to have a pressure alarm to stationary furniture.</p> <p>A Care Plan for falls, initiated on 08/24/11, included, but was not limited to, an intervention of, "Pressure alarm to stationary furniture."</p> <p>In an interview with Unit Manager #2, on 09/07/11 at 3:00 P.M., she indicated, "[Resident #12] did not have an alarm on his chair when he fell on 09/06/11, we</p>				<p>prevention interventions are in place as indicated per C.N.A. assignment sheets and care plans. Random audits of fall prevention interventions being in place as indicated per resident specific plan of care and C.N.A. assignment sheet will be conducted per DNS/designee, 3x week for 4 weeks, then 2x week for 4 weeks and then weekly for 4 weeks.</p> <p>4. Corrective actions will be monitored by ED in monthly QA&A meeting monthly for 6 months and no further corrective actions are necessary.</p> <p>5. Correction will be completed by Sept. 27, 2011.</p>		

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F0332 SS=D	<p>added that as an intervention on 09/06/11."</p> <p>The Policy and Procedure for "Falls Management Clinical Guidelines," provided by the DoN [Director of Nursing] on 09/09/11 at 2:15 P.M., indicated, "The center implements the falls prevention and intervention program including:...Appropriate interventions are implemented..."</p> <p>This deficiency was cited on 7/22/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-45(a)(2)</p>			F0332			09/27/2011
	<p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview, and record review the facility failed to ensure it was free of a medication error rate greater than 5%, with the facility having 3 medication errors out of 40 opportunities for error, resulting in a 7.5% medication error rate. This affected 3 of 15 residents observed during medication passes</p>				<p>1. Corrective actions for residents #55, #63 and #32 were taken as indicated.</p> <p>2. All other residents with the potential to be affected by the alleged deficient practice have been identified and corrective actions taken as indicated.</p>		

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	<p>(Residents #55, #63, #32), and 3 of 5 nurses observed to pass medications. (Nurse Unit Manager, LPN #1, LPN #2)</p> <p>Findings include:</p> <p>1. On 9/7/11 at 11:20 a.m., LPN #1 was observed to draw up insulin for Resident #55. She drew up Novolog insulin in an insulin syringe and indicated it was 6 units. She indicated the resident's blood sugar was 260 and the sliding scale indicated 6 units were to be given.</p> <p>The syringe was observed, after the LPN drew up the insulin, on 9/7/11 at 11:20 a.m. The syringe markings indicated the insulin was drawn up to the 7 unit mark. LPN #1 proceeded to enter the room, and prepare to give the insulin to the resident. At that time, she was stopped and requested to double check the insulin dosage. She looked at the syringe and pushed the plunger slightly. She stated, "I thought it was at 6." The syringe was observed and had been adjusted to the 6 unit mark. The LPN proceeded to re-enter the room and administer the insulin.</p> <p>Resident #55's clinical record was reviewed for medication orders, on 9/8/11 at 9:15 a.m. The resident had orders for Novolog to be given before meals and at bedtime, in a sliding scale format. The</p>				<p>3. The following measures were implemented to prevent any incidents of the alleged deficient practice: Licensed staff were re-educated related to medication administration, including but not limited to, drawing up insulin as per physician order and flushing gastrostomy tube prior to the administration of medications. In addition, individual action plans were developed and implemented for the unit manager, LPN#1, and LPN#2 in response to medication observations conducted per surveyors during revisit.</p> <p>4. Corrective actions will be monitored by ED in monthly QA&A meeting monthly for 6 months and no further corrective actions are necessary.</p> <p>5. Correction will be completed by Sept. 27, 2011.</p>		

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	<p>orders, dated 6/8/11, indicated the resident was supposed to get 6 units of Novolog insulin for a blood sugar between 251 and 300.</p> <p>2. The Nurse Unit Manager for the 500 hall was observed administering medications to Resident #63 on 9/8/11 at 1:30 p.m. The medications included, but were not limited to, metoclopramide [Reglan], to assist food movement through the stomach] 5 milligrams [mg] per milliliter [ml], 5 ml. The Unit Manager prepared to give the medication through the resident's gastrostomy tube. She checked placement of the tube by inserting a bolus of air into the stomach and listening with a stethoscope for air movement. She then took the plunger out of a syringe and attached the syringe to the tube. She poured an amount of water into the tube to flush the tube prior to administering the medication. The water remained in the chamber of the syringe and did not go into the stomach. The Nurse indicated, at that time, that the tube sometimes did not work by gravity and fluids would need some help by pushing the plunger lightly into the syringe. At that time, she picked up the medication cup with the 5 ml of metoclopramide in it and poured the medication into the syringe. It mixed in with the water that was supposed to be the flush before the</p>						

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	<p>medication. She then used the plunger to push lightly into the barrel of the syringe, assisting the water and medication to enter the stomach.</p> <p>The failure to flush the tube prior to administration of the medication resulted in a medication error.</p> <p>3. During observation of the medication pass, on 09/07/11 at 10:10 A.M., LPN #2 indicated she was preparing to administer medications through a g-tube for Resident #32. LPN #2 prepared Lortab [narcotic pain medication] 10 mg [milligrams]/20 ml [milliliters].</p> <p>LPN #2 was then observed to enter the room of Resident #32. At that time, Resident #32 was observed to be lying in her bed. LPN #2 was observed to fill a graduated cylinder with tap water. In an interview, at that time, LPN #2 indicated the graduated cylinder contained 240 cc of water, LPN #2 further indicated that Resident #32 received a 240 cc flush with meds.</p> <p>At that time, LPN #2 was observed to administer the Lortab liquid via g-tube, without flushing the g-tube with water.</p> <p>The clinical record of Resident #32 was reviewed on 09/07/11 at 3:15 P.M. The record indicated the diagnoses of Resident</p>						

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	<p>#32 included, but was not limited to, hemiplegia.</p> <p>The August 2011 Physician's Order Recap included, but was not limited to, orders for "Lortab 10 mg...Gastrostomy tube... three times a day Everyday. The recaps further indicated, "...Enteral Feedings...Special Instructions: Water flush PEG tube 180 mls [milliliters] every 4 hours Everyday...Flush Peg-tube with 30cc before and after administration of medication-every shift..."</p> <p>The current care plan, dated 08/10/10, indicated, "Dependent on tube feeding/inadequate oral intake due to: Dysphagia, CVA [stroke]..." with interventions which included, but were not limited to: "...water flushed as ordered..."</p> <p>The failure to flush the tube before the medication administration, resulted in one [1] medication error for this observation.</p> <p>The Policy and Procedure for Medication Administration, provided by the DoN [Director of Nursing] on 09/07/11 at 2:15 P.M., indicated, "Medication Administration: 1. Medications are administered in accordance with written orders of the Prescriber..."</p>						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155248		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 09/09/2011	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BRENTWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 30 EAST CHANDLER AVE EVANSVILLE, IN47713			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>The Geriatric Medication Handbook, Eighth Edition, reviewed on 09/09/11 at 3:00 p.m., indicated the following: "Medication administration via enteral tubes procedures: ...8. Check for proper tube placement...12. Put 15-30 ml [milliliters] water in syringe and flush tubing using gravity flow...13. Pour dissolved/diluted medication in syringe...14. Flush tubing with 15-30 ml of water, or prescribed amount..."</p> <p>During an interview with the LPN #2, on 09/07/11 at 10:20 A.M., she indicated, "the g-tube should be flushed before and after meds..."</p> <p>This deficiency was cited on 7/22/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>						